SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Sterling Life Insurance Company

Product Name: LTC Application Revision	SERFF Tr Num: LFPL-125483000	State: ArkansasLH
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed	State Tr Num: 38146
Sub-TOI: LTC03I.001 Qualified	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Marie Bennett, Harris Shearer
	Author: Mary Boyden	Disposition Date: 10/15/2008
	Date Submitted: 02/12/2008	Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: Resubmission	Previous Filing Number: unknown
Group Market Size:	Overall Rate Impact:
Group Market Type:	Filing Status Changed: 10/15/2008
	State Status Changed: 10/15/2008
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Enclosed is an application revision for the submission of a Tax-Qualified Comprehensive Long Term Care Insurance product for Sterling Life Insurance Company, which was approved by your department on February 14, 2007. We have removed the Unlimited Lifetime Multiplier from page one of the application. The application from number approved by your department is LTCAPP (03/06) AR. We have revised the form number to LTCAPP (Rev.1/08) AR to reflect the revision.

SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

Company and Contact

Filing Contact Information

(This filing was made by a third party - lifeplansinc)

Mary Boyden, Filing Consultant
51 Sawyer Road
Waltham, MA 02453

mboyden@lifeplansinc.com
(781) 893-7600 [Phone]
(781) 893-6905[FAX]

Filing Company Information

Sterling Life Insurance Company
1000 N. Milwaukee Ave. 6th Floor
Glenview, IL 60025
(360) 392-9251 ext. [Phone]

CoCode: 77399
Group Code: 317
Group Name:
FEIN Number: 13-1867829

State of Domicile: Illinois
Company Type:
State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	10/15/2008	10/15/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Marie Bennett	09/03/2008	09/03/2008	Mary Boyden	10/10/2008	10/10/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Application Error	Note To Reviewer	Mary Boyden	06/23/2008	06/23/2008

SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/15/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Cover Letter	Filed	Yes
Supporting Document	Authorization Letter	Filed	Yes
Form	LTC Application	Withdrawn	Yes
Form	Application	Approved	Yes

SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/03/2008
Submitted Date	09/03/2008
Respond By Date	10/03/2008

Dear Mary Boyden,

This will acknowledge receipt of the captioned filing.

Objection 1

- LTC Application (Form)

Comment: Mary, attach your corrected application to the form schedule.

Please feel free to contact me if you have questions.
Sincerely,
Marie Bennett

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/10/2008
Submitted Date	10/10/2008

Dear Harris Shearer,

Comments:

Response 1

Comments: Attached please find the corrected version of the application as requested.

Related Objection 1

Applies To:

- LTC Application (Form)

Comment:

Mary, attach your corrected application to the form schedule.

Changed Items:

SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application	LTC APP (Rev. 1/08)		Application/Enrollment Form	Revised	LTC APP (03/06) AR		LTCAPP (Rev. 1.08) AR.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Mary Boyden

SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Mary Boyden on 06/23/2008 10:34 AM

Subject:

Application Error

Comments:

After we filed this application revision we noticed the form number was not consistent through out the form. We have since corrected the error. Please tell me how to proceed with this filing.

SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: LTCAPP (Rev. 1/08) AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Withdrawn	LTCAPP (Rev. 1/08) AR	Application/ Enrollment Form	LTC Application	Revised	Replaced Form #: LTCAPP (03/06) AR Previous Filing #: unknown	0	LTCAPP (Rev. 1.08) AR.pdf
Approved	LTC APP (Rev. 1/08)	Application/ Enrollment Form	Application	Revised	Replaced Form #: LTC APP (03/06) AR Previous Filing #:		LTCAPP (Rev. 1.08) AR.pdf

STERLING LIFE INSURANCE COMPANY, Glenview IL

INTEGRATED LONG TERM CARE INSURANCE APPLICATION

FORM LTC POL (03/06)

Application No.: *Business Source Code:* _____

Application Date (Month — Date — Year) | Current Policyholder? ☐ Yes ☐ No | Requested Effective Date (if left blank it will be date of approval) | Mail Policy To: ☐ Agent ☐ Insured | For Spousal Discount Spouse's Application No.

Proposed Insured Information Married ☐ Yes ☐ No

Date of Birth (Month — Date — Year) | Sex ☐ M ☐ F | Age | Social Security Number | Telephone Number

Best Time To Call: _____ ☐ a.m. ☐ p.m.

Name (First Name, Middle Initial, Last Name):

Address:

City: State: Zip Code:

Daily Benefit: $

Lifetime Multiplier: ☐ 500 ☐ 1000 ☐ 2000

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Home Health Care/Adult Day Care Services ☐ 50% ☐ 100%

Optional Riders *(check all that apply):*

☐ Inflation Protection

☐ Non-Forfeiture

Premium:_____ Billing Mode: ☐ Monthly APC ☐ Semi-Annual ☐ Annual

PROTECTION AGAINST UNINTENDED LAPSE. I understand that I have the right to designate one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

☐ I elect NOT to designate any person to receive such notice.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

Name:

Address:

City: State: Zip Code:

1. Do you intend to replace any of your medical or health insurance coverage with this policy? ☐ Yes ☐ No
2. Do you currently have or did you have within the past 12 months, another Long Term Care, Nursing Home or Home Health Care Policy or Certificate in force (including Health Care Service Contract or HMO)? ☐ Yes ☐ No

If "YES", Please provide details below

Name of Company	Lapsed (yes/no)	Applied for (yes/no)	In Force (yes/no)	Type & Amount of Benefit	Replaced (yes/no)	When (date)

Agent shall list any other health insurance policies they have sold to proposed insured:

1. List policies sold that are still in force: _____
2. List policies sold in the past five (5) years that are no longer in force: _____

Section 2

Please list all Medications currently taken:

Name of Medication	Daily Dosage (1x, 2x, 3x, etc.) Strength (# of mgs.)	How Long Taking Medication	Reasons for Taking

MEDICAL HISTORY

1. Do you currently:
   - Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, respirator, oxygen equipment, motorized cart or lift for transporting to bed, chair or upstairs? ☐ Yes ☐ No
   - Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, mobility, transferring, or maintaining continence? ☐ Yes ☐ No
   - Need help, assistance or supervision in performing two or more of the following everyday activities: managing or taking medication, doing housework, laundry, shopping or meal preparation? ☐ Yes ☐ No
   - Require confinement in a bed, your home, a hospital or nursing home, receiving home health care, Adult Day Care or other Long Term Care Services? ☐ Yes ☐ No
   - Require or within the past 2 years has a person or institution acted on your behalf due to any mental or physical disability? ☐ Yes ☐ No
2. Have you ever experienced symptoms of, been diagnosed with, consulted a medical professional for, been treated for or advised to be treated for:
   - a. Diabetes using insulin through injections or a pump? ☐ Yes ☐ No
   - b. Cancer which has spread from the original site or organ? ☐ Yes ☐ No
   - c. Systemic Lupus Erythematosus, sarcoidosis? ☐ Yes ☐ No
   - d. Amputation due to disease or medical condition or organ transplant? ☐ Yes ☐ No
   - e. Ataxia, transverse myelitis, myasthenia gravis, Pagets Disease or post-polio syndrome? ☐ Yes ☐ No
   - f. Alzheimer's disease, memory loss, confusion, senility, dementia or organic brain syndrome, Schizophrenia or psychosis? ☐ Yes ☐ No
   - g. More than one stroke or transient ischemic attack (TIA), or one of each? ☐ Yes ☐ No
   - h. Parkinson's Disease, Muscular Dystrophy, Huntington's Chorea, or Motor Neuron Disease? ☐ Yes ☐ No
   - i. Lou Gehrig's Disease (ALS), demyelinating disease or Multiple Sclerosis? ☐ Yes ☐ No
   - j. Kidney or renal failure, Polycystic Kidney Disease? ☐ Yes ☐ No
   - k. Liver disease or cirrhosis? ☐ Yes ☐ No
   - l. Acquired immune deficiency syndrome (AIDS), AIDS related complex, AIDS related conditions or tested positive for HIV? ☐ Yes ☐ No

IF ANY OF THE ABOVE QUESTIONS HAVE BEEN ANSWERED 'Yes', COVERAGE IS NOT AVAILABLE.

Section 3

	Proposed Insured
Proposed Insured's Height/Weight: ☐ ft. ☐☐ inches ☐☐☐ lbs.	
Have you used any tobacco products within the past 24 months?	☐ Yes ☐ No
During the past 5 years have you received medical advice, been diagnosed or received treatment by a member of the medical profession for any of the following conditions:	
(Please circle the conditions that apply)	
1. High Blood Pressure, Chest Pain, Heart Attack, Stroke, Transient Ischemic Attack (TIA), Irregular Heart Beat, Heart Valve Disorder, Carotid Artery Disease, Bypass Surgery, Angioplasty or Aneurysm?	☐ Yes ☐ No
2. Cancer, Leukemia, Lymphoma, Melanoma, Hodgkin's Disease or Multiple Myeloma?	☐ Yes ☐ No
3. Arthritis, Fractures, Joint Disorders or Replacement, Spine, Hip, Back or Knee Disorders, Osteoporosis or Scleroderma?	☐ Yes ☐ No
4. Diabetes, Peripheral Vascular Disease, Macular Degeneration or other Glandular Disease?	☐ Yes ☐ No
5. Lung Disorder, Emphysema, Chronic Obstructive Pulmonary Disease, Asthma, Sleep Apnea or other Breathing Disorders?	☐ Yes ☐ No
6. Alcoholism, Drug Abuse or Chronic Hepatitis?	☐ Yes ☐ No
7. Paralysis, Numbness, Balance Problems or Tremors?	☐ Yes ☐ No
8. Epilepsy, Seizures, Convulsive Disorders, Depression or Mental Disorders?	☐ Yes ☐ No
9. Been recommended to have surgery or been hospitalized for any reason?	☐ Yes ☐ No
10. Been diagnosed or received treatment by a member of the medical profession for any condition not listed above?	☐ Yes ☐ No
11. Are you receiving any type of disability benefits, such as worker's compensation, short-term disability benefits, or Social Security Disability Income (SSDI)?	☐ Yes ☐ No

Provide details to "YES" answers below.

Note: Proposed Insureds who are 72 years of age or older and have not seen a doctor for any reason in the past 2 years will be required to have a physical exam.

Details to "**YES**" answers in Section 3, questions 1-11

Medical Condition(s)	Treatment Dates To/From	Type of Treatment Received	Doctor's name, address & telephone no.

Section 4

CONDITIONS OF APPLICATION, AUTHORIZATION AND RECEIPT

I understand and agree that coverage will not begin until Sterling Life Insurance Company has approved my application and assigned an Effective Date. I have given the above answers to obtain this insurance. These answers are true and complete to the best of my knowledge and belief. I know that: 1) insurance could be void or benefits denied subject to the Incontestability Provision if the answers on this application are incorrect or untrue; 2) if the premium quoted in the application includes a spousal discount and coverage is not approved for both spouses, the premium due for the person who is covered will be the regular premium otherwise due; and 3) coverage for both spouses must continue in force for the discount to apply to any given period of in-force coverage. A copy of this application will become part of any policy that is issued to me.

I authorize Sterling Life Insurance Company or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB) or consumer reporting agency to release to Sterling Life Insurance Company any information regarding me for the purpose of evaluating this application for insurance. I also authorize Sterling Life Insurance Company or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization will be valid from the date signed for a period of 2½ years. I have read this authorization and understand that I or my authorized representative can receive a copy. I agree that a photographic copy of this authorization shall be as valid as the original.

I have received: ☐ An Outline of Coverage.
I have received: ☐ A Long-Term Care Shopper's Guide.
I have received: ☐ The Long-Term Care Insurance Potential Rate Increase Disclosure Form.

Caution: If your answers on this application are incorrect or untrue, Sterling has the right to deny benefits or rescind your policy.

INFLATION PROTECTION BENEFIT:

If I have **not elected** the Inflation Protection Benefit: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the inflation protection rider, and I reject inflation protection." _____ Initial

Proposed Insured: _____ Date: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

IMPORTANT NOTICE

Please read this application. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to Sterling within 10 days if any information shown on this application is not correct and complete or if any medical history has not been included.

FOR AGENT USE ONLY

I certify that: (1) the information supplied by the applicant has been truly and accurately recorded on this application; (2) I am not aware of any other information relating to the applicant's health which might have a bearing on the risk; (3) the information was taken from the applicant in person.

Signed and dated at: _____ (State) on _____ (month) _____ (date), _____ (year)

Agent's Signature: _____ Agent Code _____

STERLING LIFE INSURANCE COMPANY, GLENVIEW IL

LONG-TERM CARE INSURANCE APPLICATION RECEIPT

I have applied for an insurance policy from Sterling Life Insurance Company (Sterling). With my application I have submitted a check, money order or cash in the amount of $_____.

I understand that this payment will be held by Sterling and, if my application is approved and a policy is issued to me, Sterling will accept this payment and apply it as the premium for the first period of coverage under the policy.

I understand that this policy will **NOT** become effective unless my application is approved in writing by Sterling and a policy is delivered to me. I understand that if Sterling approves my application, I will have coverage beginning on the date of such approval by Sterling. If my application is not approved by Sterling, the above premium will be refunded to me. I understand that in no event will I have coverage for the period between today and the date on which Sterling approves or disapproves my application.

If the payment quoted in the application includes a spousal discount and coverage is approved for one spouse but not the other, the payment due for the person who is approved will be the regular payment otherwise due.

Proposed Insured's Signature: _____ Date: _____

Agent's Signature: _____ Agent Code: _____ Date: _____

Form No. LTCRECEIPT

Top Copy: Home Office Bottom Copy: Applicant

STERLING LIFE INSURANCE COMPANY, GLENVIEW IL

LONG-TERM CARE INSURANCE APPLICATION RECEIPT

I have applied for an insurance policy from Sterling Life Insurance Company (Sterling). With my application I have submitted a check, money order or cash in the amount of $_____.

I understand that this payment will be held by Sterling and, if my application is approved and a policy is issued to me, Sterling will accept this this payment and apply it as the premium for the first period of coverage under the policy.

I understand that this policy will **NOT** become effective unless my application is approved in writing by Sterling and a policy is delivered to me. I understand that if Sterling approves my application, I will have coverage beginning on the date of such approval by Sterling. If my application is not approved by Sterling, the above premium will be refunded to me. I understand that in no event will I have coverage for the period between today and the date on which Sterling approves or disapproves my application.

If the payment quoted in the application includes a spousal discount and coverage is approved for one spouse but not the other, the payment due for the person who is approved will be the regular payment otherwise due.

Proposed Insured's Signature: _____ Date: _____

Agent's Signature: _____ Agent Code: _____ Date: _____

Form No. LTCRECEIPT

Top Copy: Home Office Bottom Copy: Applicant

STERLING LIFE INSURANCE COMPANY, Glenview IL

INTEGRATED LONG TERM CARE INSURANCE APPLICATION

FORM LTC POL (03/06)

Application No.: *Business Source Code:* _____

Application Date (Month — Date — Year) | Current Policyholder? ☐ Yes ☐ No | Requested Effective Date (if left blank it will be date of approval) | Mail Policy To: ☐ Agent ☐ Insured | For Spousal Discount Spouse's Application No.

Proposed Insured Information Married ☐ Yes ☐ No

Date of Birth (Month — Date — Year) | Sex ☐ M ☐ F | Age | Social Security Number | Telephone Number

Best Time To Call: _____ ☐ a.m. ☐ p.m.

Name (First Name, Middle Initial, Last Name):

Address:

City: State: Zip Code:

Daily Benefit: $

Lifetime Multiplier: ☐ 500 ☐ 1000 ☐ 2000

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Home Health Care/Adult Day Care Services ☐ 50% ☐ 100%

Optional Riders *(check all that apply):*

☐ Inflation Protection

☐ Non-Forfeiture

Premium:_____ Billing Mode: ☐ Monthly APC ☐ Semi-Annual ☐ Annual

PROTECTION AGAINST UNINTENDED LAPSE. I understand that I have the right to designate one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

☐ I elect NOT to designate any person to receive such notice.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

Name:

Address:

City: State: Zip Code:

1. Do you intend to replace any of your medical or health insurance coverage with this policy? ☐ Yes ☐ No
2. Do you currently have or did you have within the past 12 months, another Long Term Care, Nursing Home or Home Health Care Policy or Certificate in force (including Health Care Service Contract or HMO)? ☐ Yes ☐ No

If "YES", Please provide details below

Name of Company	Lapsed (yes/no)	Applied for (yes/no)	In Force (yes/no)	Type & Amount of Benefit	Replaced (yes/no)	When (date)

Agent shall list any other health insurance policies they have sold to proposed insured:

1. List policies sold that are still in force: _____
2. List policies sold in the past five (5) years that are no longer in force: _____

Section 2

Please list all Medications currently taken:

Name of Medication	Daily Dosage (1x, 2x, 3x, etc.) Strength (# of mgs.)	How Long Taking Medication	Reasons for Taking

MEDICAL HISTORY

1. Do you currently:
   - Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, respirator, oxygen equipment, motorized cart or lift for transporting to bed, chair or upstairs? ☐ Yes ☐ No
   - Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, mobility, transferring, or maintaining continence? ☐ Yes ☐ No
   - Need help, assistance or supervision in performing two or more of the following everyday activities: managing or taking medication, doing housework, laundry, shopping or meal preparation? ☐ Yes ☐ No
   - Require confinement in a bed, your home, a hospital or nursing home, receiving home health care, Adult Day Care or other Long Term Care Services? ☐ Yes ☐ No
   - Require or within the past 2 years has a person or institution acted on your behalf due to any mental or physical disability? ☐ Yes ☐ No
2. Have you ever experienced symptoms of, been diagnosed with, consulted a medical professional for, been treated for or advised to be treated for:
   - a. Diabetes using insulin through injections or a pump? ☐ Yes ☐ No
   - b. Cancer which has spread from the original site or organ? ☐ Yes ☐ No
   - c. Systemic Lupus Erythematosus, sarcoidosis? ☐ Yes ☐ No
   - d. Amputation due to disease or medical condition or organ transplant? ☐ Yes ☐ No
   - e. Ataxia, transverse myelitis, myasthenia gravis, Pagets Disease or post-polio syndrome? ☐ Yes ☐ No
   - f. Alzheimer's disease, memory loss, confusion, senility, dementia or organic brain syndrome, Schizophrenia or psychosis? ☐ Yes ☐ No
   - g. More than one stroke or transient ischemic attack (TIA), or one of each? ☐ Yes ☐ No
   - h. Parkinson's Disease, Muscular Dystrophy, Huntington's Chorea, or Motor Neuron Disease? ☐ Yes ☐ No
   - i. Lou Gehrig's Disease (ALS), demyelinating disease or Multiple Sclerosis? ☐ Yes ☐ No
   - j. Kidney or renal failure, Polycystic Kidney Disease? ☐ Yes ☐ No
   - k. Liver disease or cirrhosis? ☐ Yes ☐ No
   - l. Acquired immune deficiency syndrome (AIDS), AIDS related complex, AIDS related conditions or tested positive for HIV? ☐ Yes ☐ No

IF ANY OF THE ABOVE QUESTIONS HAVE BEEN ANSWERED 'Yes', COVERAGE IS NOT AVAILABLE.

Section 3

	Proposed Insured
Proposed Insured's Height/Weight: ☐ ft. ☐☐ inches ☐☐☐ lbs.	
Have you used any tobacco products within the past 24 months?	☐ Yes ☐ No
During the past 5 years have you received medical advice, been diagnosed or received treatment by a member of the medical profession for any of the following conditions:	
(Please circle the conditions that apply)	
1. High Blood Pressure, Chest Pain, Heart Attack, Stroke, Transient Ischemic Attack (TIA), Irregular Heart Beat, Heart Valve Disorder, Carotid Artery Disease, Bypass Surgery, Angioplasty or Aneurysm?	☐ Yes ☐ No
2. Cancer, Leukemia, Lymphoma, Melanoma, Hodgkin's Disease or Multiple Myeloma?	☐ Yes ☐ No
3. Arthritis, Fractures, Joint Disorders or Replacement, Spine, Hip, Back or Knee Disorders, Osteoporosis or Scleroderma?	☐ Yes ☐ No
4. Diabetes, Peripheral Vascular Disease, Macular Degeneration or other Glandular Disease?	☐ Yes ☐ No
5. Lung Disorder, Emphysema, Chronic Obstructive Pulmonary Disease, Asthma, Sleep Apnea or other Breathing Disorders?	☐ Yes ☐ No
6. Alcoholism, Drug Abuse or Chronic Hepatitis?	☐ Yes ☐ No
7. Paralysis, Numbness, Balance Problems or Tremors?	☐ Yes ☐ No
8. Epilepsy, Seizures, Convulsive Disorders, Depression or Mental Disorders?	☐ Yes ☐ No
9. Been recommended to have surgery or been hospitalized for any reason?	☐ Yes ☐ No
10. Been diagnosed or received treatment by a member of the medical profession for any condition not listed above?	☐ Yes ☐ No
11. Are you receiving any type of disability benefits, such as worker's compensation, short-term disability benefits, or Social Security Disability Income (SSDI)?	☐ Yes ☐ No

Provide details to "YES" answers below.

Note: Proposed Insureds who are 72 years of age or older and have not seen a doctor for any reason in the past 2 years will be required to have a physical exam.

Details to "**YES**" answers in Section 3, questions 1-11

Medical Condition(s)	Treatment Dates To/From	Type of Treatment Received	Doctor's name, address & telephone no.

Section 4

CONDITIONS OF APPLICATION, AUTHORIZATION AND RECEIPT

I understand and agree that coverage will not begin until Sterling Life Insurance Company has approved my application and assigned an Effective Date. I have given the above answers to obtain this insurance. These answers are true and complete to the best of my knowledge and belief. I know that: 1) insurance could be void or benefits denied subject to the Incontestability Provision if the answers on this application are incorrect or untrue; 2) if the premium quoted in the application includes a spousal discount and coverage is not approved for both spouses, the premium due for the person who is covered will be the regular premium otherwise due; and 3) coverage for both spouses must continue in force for the discount to apply to any given period of in-force coverage. A copy of this application will become part of any policy that is issued to me.

I authorize Sterling Life Insurance Company or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB) or consumer reporting agency to release to Sterling Life Insurance Company any information regarding me for the purpose of evaluating this application for insurance. I also authorize Sterling Life Insurance Company or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization will be valid from the date signed for a period of 2½ years. I have read this authorization and understand that I or my authorized representative can receive a copy. I agree that a photographic copy of this authorization shall be as valid as the original.

I have received: ☐ An Outline of Coverage.
I have received: ☐ A Long-Term Care Shopper's Guide.
I have received: ☐ The Long-Term Care Insurance Potential Rate Increase Disclosure Form.

Caution: If your answers on this application are incorrect or untrue, Sterling has the right to deny benefits or rescind your policy.

INFLATION PROTECTION BENEFIT:

If I have **not elected** the Inflation Protection Benefit: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the inflation protection rider, and I reject inflation protection." _____ Initial

Proposed Insured: _____ Date: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

IMPORTANT NOTICE

Please read this application. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to Sterling within 10 days if any information shown on this application is not correct and complete or if any medical history has not been included.

FOR AGENT USE ONLY

I certify that: (1) the information supplied by the applicant has been truly and accurately recorded on this application; (2) I am not aware of any other information relating to the applicant's health which might have a bearing on the risk; (3) the information was taken from the applicant in person.

Signed and dated at: _____ (State) on _____ (month) _____ (date), _____ (year)

Agent's Signature: _____ Agent Code _____

STERLING LIFE INSURANCE COMPANY, GLENVIEW IL

LONG-TERM CARE INSURANCE APPLICATION RECEIPT

I have applied for an insurance policy from Sterling Life Insurance Company (Sterling). With my application I have submitted a check, money order or cash in the amount of $_____.

I understand that this payment will be held by Sterling and, if my application is approved and a policy is issued to me, Sterling will accept this payment and apply it as the premium for the first period of coverage under the policy.

I understand that this policy will **NOT** become effective unless my application is approved in writing by Sterling and a policy is delivered to me. I understand that if Sterling approves my application, I will have coverage beginning on the date of such approval by Sterling. If my application is not approved by Sterling, the above premium will be refunded to me. I understand that in no event will I have coverage for the period between today and the date on which Sterling approves or disapproves my application.

If the payment quoted in the application includes a spousal discount and coverage is approved for one spouse but not the other, the payment due for the person who is approved will be the regular payment otherwise due.

Proposed Insured's Signature: _____ Date: _____

Agent's Signature: _____ Agent Code: _____ Date: _____

Form No. LTCRECEIPT

Top Copy: Home Office Bottom Copy: Applicant

STERLING LIFE INSURANCE COMPANY, GLENVIEW IL

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Proposed Insured's Signature: _____ Date: _____

Agent's Signature: _____ Agent Code: _____ Date: _____

Form No. LTCRECEIPT

Top Copy: Home Office Bottom Copy: Applicant

SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LFPL-125483000*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*38146*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*LTC Application Revision*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 02/12/2008

Comments:

No cerification required. The filing is an application revision.

Review Status:

Satisfied -Name: Application 02/12/2008

Comments:

Application is attached to the from schedule tab.

Review Status:

Satisfied -Name: Health - Actuarial Justification 02/12/2008

Comments:

No rates are being filed.

Review Status:

Satisfied -Name: Outline of Coverage 02/12/2008

Comments:

No outline of coverage is being filed.

Review Status:

Satisfied -Name: Cover Letter Filed 10/15/2008

Comments:

Attachment:

AR DOI Letter.pdf

Review Status:

Satisfied -Name: Authorization Letter Filed 10/15/2008

Comments:

Attachment:

Authorization.pdf

LifePlans
EXPERIENCE
QUALITY
INNOVATION

51 Sawyer Road
Suite 340
Waltham, MA 02453
(781) 893-7600
Fax: (781) 647-3552
www.lifeplansinc.com

February 12, 2008

AR Dept. of Insurance
LTC Insurance Analyst
1200 West 3rd Street
Little Rock, AR 72201

RE: **Sterling Life Insurance Company**
Qualified Long-Term Care Insurance Filing
FEIN Number: 13-1867829
NAIC Number: 77399

Dear: LTC Insurance Analyst,

Enclosed is an application revision for the submission of a Tax-Qualified Comprehensive Long Term Care Insurance product for Sterling Life Insurance Company, which was approved by your department on February 14, 2007. We have removed the Unlimited Lifetime Multiplier from page one of the application. The application from number approved by your department is LTCAPP (03/06) AR. We have revised the form number to LTCAPP (Rev.1/08) AR to reflect the revision.

Thank you for your review. If you need anything further or wish to discuss this filing, please feel free to call toll-free (800) 525-7279, extension: 312 or fax your request to (800) 397-2968. If everything is in order, we will appreciate receiving your approval.

Sincerely,

Mary Boyden

Mary Boyden
Filing Consultant

STERLING Life Insurance Company

DATE: June 23, 2006

TO: State Insurance Department

RE: **Qualified Long-Term Care Insurance Filings**

I hereby authorize our filing consultants, Kathleen Andrews, Tara Travers and Mary Boyden to communicate with the Insurance Department, review and submit rates, and receive information from the Department with respect to the Qualified Long-Term Care Insurance filing for Sterling Life Insurance Company.

Any questions concerning this authorization should be brought to my immediate attention.

Signature of Company Officer

Craig Bodway, Esq., Assistant Secretary
Name/Title